

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 1 1948

Registration District No. 282

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4424

State File No.

30663

Registrar's No.

112

1. PLACE OF DEATH:

(a) County HUMAN Polk
(b) City or town HUMANSVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Humanville Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 days
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT
FULL NAME

Kathy Anne Bybee

3. (b) If veteran,

name war NI

3. (c) Social Security

No. NO

4. Sex F 1

5. Color or
race W

6. (a) Single, widowed, married,
divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if
alive _____ years
(Day) (Year)

7. Birth date of deceased

May
(Month)

22
(Day)

1947
(Year)

8. AGE:

Years

Months

Days

If less than one day

1

3

15

hr.

min.

9. Birthplace

Hermitage
(City, town, or county)

MO U
(State or foreign country)

10. Usual occupation

Infant

11. Industry or business

MOTHER FATHER

12. Name

J. W. Bybee

13. Birthplace

Cross Timbers, MO
(City, town, or county)

MO U
(State or foreign country)

14. Maiden name

Erma Smith

15. Birthplace

Hermitage
(City, town, or county)

MO U
(State or foreign country)

16. (a) Informant

Erma Bybee

(b) Address

Hermitage, MO

17. (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

9-9-48
(Month) (Day) (Year)

(c) Place: burial or cremation

Hermitage Cemetery

18. (a) Signature of funeral director

Hubert A. ...

(b) Address

Hermitage, MO

19. (a)

Sept. 20-1948
(Date received registrar)

Ralph ...
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Hickory
(c) City or town Hermitage
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 7
year 1948 hour 6 minute 55P M.

21. I hereby certify that I attended the deceased from

9-5-48 to 9-7-48

that I last saw her alive on 9-7-48
and that death occurred on the date and hour stated above.

Immediate cause of death

Anterior Polymyositis, acute

Duration

Due to _____

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature W. H. Robinson
Address Hermitage, MO Date signed 9/11/48

AUG 22 1948

RECEIVED

District Health Officer No. 7,

District File Number 8-48-1130

Date Filed 9-29-48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,
working under my personal supervision.

Signed Chas. Gilbert Hathaway

Licensed Embalmer No. 4267

P. O. Address Wheatland, Md

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.